Medical Assistance Provider Bulletin

Attention: All Title XIX Audiologists, Speech/Hearing Clinics, and Hearing Aid Suppliers

Subject: Policy Changes and Clarification

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I. ADDITIONAL SERVICES BILLABLE BY HEARING AID DEALERS

A. Introduction

The Wisconsin Medical Assistance Program (WMAP) is changing its policy regarding the delivery of hearing health services. Effective for dates of service on and after July 1, 1989, the WMAP will remove the current restriction requiring that hearing evaluations be performed only by a certified audiologist. Hearing aid dealers may now perform hearing evaluations for the purposes of fitting and dispensing a hearing aid to recipients 22 years of age and over and developmentally unimpaired. The conditions for inclusion of these additional services are outlined below. This new policy will be reviewed one year after its implementation.

Wisconsin Department of Health and Social Services, Division of Health, Bureau of Health Care Financing, Provider/Recipient Services, P.O. Box 309, Madison, Wisconsin 53701

B. Policy

Effective with dates of service on and after July 1, 1989, limited hearing evaluations and hearing aid checks will be included as allowable hearing aid dealer services, although, in keeping with existing industry practice, they will not be reimbursable.

The allowable procedures are:

- Pure tone audiometry (threshold); air only
- Pure tone audiometry; air and bone, with or without masking
- Speech audiometry; threshold only
- Speech audiometry; threshold and discrimination
- Basic comprehensive audiometry (pure tone, air and bone, and speech, threshold and discrimination combined)
- Hearing aid examination and selection; monaural
- Hearing aid examination and selection; binaural
- Hearing aid check; monaural
- Hearing aid check; binaural

Claims submitted by hearing aid dealers for the above procedures will be denied.

Note: Hearing aid dispensers who are also Medical Assistance certified audiologists may continue to bill for these procedures as usual.

The WMAP will allow these additional services only in cases where:

a. the recipient is 22 years of age or older;
b. the prescribing physician determines that the recipient is not impaired cognitively or behaviorally; and
c. the prescribing physician determines that the recipient has no other special needs which would require the services of a certified audiologist.

The Physician Otological Report for Hearing Aid Evaluation (PA/OF) has been revised to allow the prescribing physician to appropriately refer the patient to either an audiologist or hearing aid dealer. The revised PA/OF will be available from E.D.S. Federal Corporation sometime in August 1989. Use the current PA/OF until the revised forms are available. (Refer to Attachment B-8a of MAPB-087-015-D/002-HA, dated September 1, 1987, to see a sample of the current PA/OF.) In the interim, since physicians are unaware of this policy change, you should share this bulletin with the prescribing physician and request that s/he make special note if the recipient meets the criteria for testing by a hearing aid dealer.

C. Restrictions to Place of Service Code "4"

Effective for dates of services on and after July 1, 1989, in order for the hearing aid dealer to use place of service code "4" (home) for hearing evaluations, the prescribing physician must indicate on the PA/OF that home testing is required. However, other covered hearing aid dealer services may be performed at home without a separate designation on the PA/OF prescription.

D. Prior Authorization for Hearing Aids

Prior authorization is required for fitting and dispensing hearing aids. Attachment 1 is a summary of prior authorization instructions. Refer to MAPB-087-015-D/002-HA, dated September 1, 1987, for specific instructions on filling out the PA/ARF1, PA/ARF2, and the PA/OF forms.

II. BINAURAL CODES FOR BATTERIES

In an effort to facilitate the processing of hearing aid battery claims, the WMAP has added additional battery codes (W6924 through W6939) which will help us distinguish between batteries provided for a monaural hearing aid and batteries provided for binaural hearing aids. There is no policy change in the coverage of hearing aid batteries:

> Hearing aid batteries are limited to twelve (12) batteries per 30-day period per recipient, per provider, per hearing aid.

The additional procedure codes have been added for the sole purpose of making the processing of hearing aid battery claims more efficient. Please refer to Attachment 2 for the appropriate procedure codes. These procedure codes are valid for dates of service on and after July 1, 1989. Effective for dates of service on and after September 1, 1989, claims will be denied if the appropriate battery procedure codes are not used. (Attachment 2 completely replaces Attachment C-4 in MAPB-087-015-D/002-HA, dated September 1, 1987.)

III. CHANGES IN PLACE OF SERVICE (POS) AND TYPE OF SERVICE (TOS) CODES FOR AUDIOLOGISTS

Effective with dates of service on and after July 1, 1989, POS "4" (home) will be an allowable POS for audiologists. However, for hearing evaluations performed in the recipient's home, the prescribing physician must indicate on the PA/OF that testing in the home is required.

Currently audiologists are billing the WMAP using both TOS "B" and TOS "W." Effective with dates of service on and after September 1, 1989, the only acceptable TOS code for audiologists will be TOS "B." Claims with TOS "W" will be denied for dates of service on and after September 1, 1989.

(See Attachment 3 which completely replaces information found on Attachment B-4 from MAPB-087-015-D/002-HA, dated September 1, 1987.)

IV. REDUCTIONS IN PRIOR AUTHORIZATION REQUIREMENTS FOR AUDIOLOGISTS

Effective with dates of service on and after July 1, 1989, the following audiology procedures will no longer require prior authorization:

Code	Description
92582	Conditioning play audiometry (to include visual reinforcement and observational audiometry)
92583	Select picture audiometry

(Attachment 4 completely replaces the information found on Attachment B-3 from MAPB-087-015-D/002-HA, dated September 1, 1987.)

V. "PAPERLESS" CLAIMS

Did you know that the average electronic claim processes in about half the time of the average paper claim? Did you know that "paperless" providers have about one-third fewer billing errors than paper billers? EDS has free software and consultation services to help providers move into the world of paperless claims. Simply fill out Attachment 5 of this bulletin and mail it to EDS, or call (608) 221-4746 and ask for the Electronic Media Claims (EMC) Unit. Join the many providers who are discovering the advantages of paperless claims!

VI. BILLING HINTS

In order to help you avoid unnecessary denied claims, a list of the most frequent billing errors resulting in Explanation of Benefit (EOB) codes and suggestions for how to resolve them is presented below.

For those who submit claims through telephone transmission or tape billing and have questions regarding the following common rejections, please contact the EMC Unit at EDS for assistance.

1. EOB CODE 281: "Recipient number is not listed on our current eligibility file. Consult with local social service agency."

   You may assume that EOB code 281 means that the recipient is not eligible. Actually, EOB code 281 means that one of the following problems are occurring:

   - The correct 10-digit Medical Assistance (MA) identification (ID) number has not been indicated in element 6 of the national HCFA 1500 claim form.

   Resolution: Remember to always use the MA ID number which appears on the valid MA ID card when submitting claims. All recipient MA ID numbers are 10 digits long.

   - The correct number of digits for the recipient's MA ID number has not been indicated.

   Resolution: You must use the valid 10-digit MA ID number.

   - The Medical Status Information code on the claim form has been indicated as part of the MA ID number.

   Resolution: The Medical Status information codes appear just before the 10-digit number on the MA ID card (i.e., "*" for Medically Needy or "N*" for Nursing Home Recipients). They must not be indicated on the claim form with the MA ID number.

The message for EOB code 281 has been changed to: "Recipient Medical Assistance identification number is incorrect. Please verify and correct the Medical Assistance number and resubmit claim." This revised message should help alleviate previous confusion.

2. EOB CODE 388: "Incorrect or invalid type of service/NDC/Accommodation Code or Ancillary Code billed."

The EOB Code 388 usually occurs when you have missing and/or incorrect information in elements 24C and/or 24G of the HCFA 1500 claim form. The EOB code most often occurs when:

- A correct procedure code has not been indicated in element 24C of the HCFA 1500 claim form.

Resolution: Indicate a valid procedure code in element 24C, "Procedure (identify)," and matching description for each service performed. Use the correct procedure code and modifier for the appropriate date of service from the listings in Attachments 3 and 5 of this bulletin. The EDS Correspondence Unit can verify if a procedure code is a valid WMAP procedure code. However, the Correspondence Unit cannot suggest valid codes to use when submitting claims.

- A correct type of service code has not been indicated in element 24G for the procedure indicated on the claim form.

Resolution: A valid type of service code for each procedure must be indicated in element 24G. Valid type of service codes may be found in Appendix 4 of this bulletin.